eye clinic of wisconsin™
One vision. Yours.®

Practice: _____
Doctor: _____
Address: _____
City/St/Zip_____
Phone: _____ Fax: _____

Request for Consultation

Date:_____

PATIENT INFORMATION

Patient Name: _____ D.O.B.: _____
If Minor- Guarantor's Name:_____
Address: _____ City: _____ State: _____ Zip:_____
Phone #1: _____ Phone #2: _____
Insurance Plan: _____ ID #: _____ Self-Pay ☐

Referring Physician: Please fax clear copy of both sides of patient's insurance card

CONSULT REQUEST

I would like to have your assistance with this patient's care. Please evaluate this patient's ocular and visual complaints, and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient and would be happy to resume the general care of the patient following your consultation and treatment and/or recommendations, as appropriate.

For Glaucoma Referrals please send a copy of the patient's past Visual Fields and Glaucoma Patient Data Sheet.
For Strabismus Referrals please include most recent refraction with prism if applicable.

Please describe the condition(s) to be evaluated and past ocular history: _____
_____
_____
_____

Most Recent Refraction:
If applicable

	Sphere	Cylinder	Axis	Prism	Base	Add
			x			
			x			

Best Corrected Visual Acuity
OD 20/_____
OS 20/_____

IOP: _____OD/_____OS

Referring Physician Signature: _____ **Date**: _____

Preferred Location:_____ **Preferred Ophthalmologist**: _____ **Urgency** _____

Form completed by: _____

APPOINTMENT SCHEDULING

☐ Please call patient to schedule, note appointment below and fax back to my office. Initials: _____

Date: _____ Time: _____ Location: _____ Provider: _____

Please fax this completed form to: (715) 870-2401 Rev. 1/25/24